MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 6126

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: Pomfret
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Pomfret
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Caroline Bryant

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Lorenzo Bryant
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Feb. 14, 1870

8. AGE: Years	Months	Days	If less than one day
78	3	17	hrs. min.

9. Birthplace: Nanjemoy Md.
(Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business:

FATHER
12. Name: James Henry Long
13. Birthplace: Chas. Co. Md.

MOTHER
14. Maiden name: Mary Caroline Boswell
15. Birthplace: Chas. Co. Md.

16. Informant: William J. Bryant
Address: Pomfret, Md.

17. Burial, cremation, or removal. Which?: Burial
Date thereof: 6/13/48 (month) (day) (year)
Cemetery or crematory: Nanjemoy Baptist
Location: Nanjemoy, Md.

18. Funeral director: Hebert H. Posey
Address: Waldorf, Md.

19. 6/12/48 (Date rec'd by registrar) 19 ... Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 1948 at 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947 to June 10 1948 and that I last saw h[illegible] alive on 5/30 & 6/9 1948

Immediate cause of death	DURATION
Congestive Heart failure	2 mos.
Due to: Arteriosclerotic Cardiovascular disease.	5 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: J. Farran Jarboe M.D.
M. D. or other
Address: La Plata Md. Date signed 6-10-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

6127

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55b

CERTIFICATE OF DEATH

Reg. Dist. No. 10W

1. PLACE OF DEATH
County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Dentsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME CUSICK, VIOLA ann

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Harry E. Cusick
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 5, 1897

8. AGE: Years	Months	Days	If less than one day
51	3	6	hrs. min.

9. Birthplace: Wisconsin (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
12. FATHER Name: Peter Feuerstein
13. FATHER Birthplace: Wisconsin
14. MOTHER Maiden name: unknown
15. MOTHER Birthplace:
16. Informant: Harry E. Cusick
Address: Dentsville, Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof 6/14/48 (month) (day) (year)
Cemetery or crematory: St. Mary's
Location: Newport, Md.
18. Funeral director: Hunter & Rayon
Address: Waldorf, Md.

19. 6/11 19 48 (Date rec'd by registrar) Julia A Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-11-48 19 at 10:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 19 47 to 6-11-48 19
and that I last saw h. alive on 6-11-48 19

Immediate cause of death	DURATION
Carcinomatosis	
Due to: Osteogenic Sarcoma of Right Femur.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Sarcoma Rt. Femur. Date of op. Jan 10/47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: Warren Jarboe M.D. M. D. or other
Address: La Plata, Md. Date signed 6-11-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6128

Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Mt. Victoria
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LeRoy Francis FORD

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Married

6.(b) Name of husband or wife: Mary Ford
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 30 1913

8. AGE: Years 34 | Months 6 | Days 26 | If less than one day ..... hrs. ..... min.

9. Birthplace: Mt Victoria md. (Town, county and state)
10. Usual occupation: State Roads
11. Industry or business

MOTHER FATHER
12. Name: John Ford
13. Birthplace: Mt Victoria, Md.

MOTHER
14. Maiden name: Bessie Key
15. Birthplace: Mt. Victoria Md.

16. Informant: Mrs Mary Ford
Address: Mt. Victoria Md

17. Burial, cremation, or removal. Which? Burial Date thereof 6/29/48 (month) (day) (year)
Cemetery or crematory: Shiloh M.E.
Location: Newburg, Md.

18. Funeral director: Hunter & Ryon
Address: Waldorf Md.

19. 6-30-48 (Date rec'd by registrar) Julia H. Raze Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 19 48 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 19 48 to June 26 19 48 and that I last saw h.... alive on June 26 19 48

Immediate cause of death	DURATION
Intra-abdominal Hemorrhage	
Due to: Acute Enterocolitis	
Due to: ?	

Other conditions: Laboratory reports revealed that patient had had Typhoid Fever in its most severe form. 9/9/48 (43)
(Incl.... pregnancy within 3 months of death)

Major findings of operation.....
Date of op.....
Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Laura Jarboe M.D.
M. D. or other
Address: La Plata Md. Date signed 6-26-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6129

13 1a

Reg. Diat. No. 106

1. PLACE OF DEATH

County: Charles

City or town: Indian Head.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles.

City or town: Indian Head.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Gwynn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Married

6.(b) Name of husband or wife: Mary Fevie Gwynn

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): June 7 1861

8. AGE:

Years	Months	Days	If less than one day
87	—	11	hrs. min.

9. Birthplace: Pomfret - Charles Co. Md.

(Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business

FATHER

12. Name: John Gwynn.

13. Birthplace: Charles Co. Md.

MOTHER

14. Maiden name: Sally Stoddard.

15. Birthplace: Charles Co. Md.

16. Informant: Clarence Gwynn

Address: Indian Head Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21, 48 (month) (day) (year)

Cemetery or crematory: M E Church

Location: Pomonkey, Md.

18. Funeral director: Stanley Penny

Address: Mason Springs Md

19. 6/18/48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 1948, at 7P (M)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to June 1948 and that I last saw him alive on June 18 1948

Immediate cause of death	DURATION
Cardiac - renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George C. Pickrell M.D.

M. D. or other

Address: Welcome Md Date signed: June 18 1948

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

6130

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

Reg. Dist. No. ~~105~~ 104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Charles
City or town Rock Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
—
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Charles
City or town Rock Point
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Verlinda J. Lancaster

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) March 19, 1868

8. AGE:

Years	Months	Days	If less than one day
80	2	13	hrs. min.

9. Birthplace Hanover Pa. (Town, county, and state)
10. Usual occupation Hsmf
11. Industry or business own home

FATHER
12. Name John Jansen
13. Birthplace P.A

MOTHER
14. Maiden name Jane Riley
15. Birthplace P.A

16. Interment Chas C. Lancaster (son)
Address Rock Point, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-3-45 (month) (day) (year)
Cemetery or crematory Holy Ghost
Location Pisgah Md
18. Funeral director Smith & Gray
Address Waldorf Md
19. 6-2 1948 William Shaw
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1948 at 8:50 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1936, to June 1, 1948
and that I last saw him alive on May 26, 1948

	DURATION
Immediate cause of death: Acute congestive heart failure	12 hrs
Due to: Chronic myocardosis	12-15 yrs
Due to: Generalized arteriosclerosis	12-15 yrs
Other conditions: Diabetes mellitus	10-12 yrs

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James L. MacKaraugh, M.D.
M. D. or other
Address La Plata, Md. Date signed 6-1-48

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

6131
131a
105

FILE No. G 116 JUN 22 1948

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, Institution, or street address where death occurred:
Physicians Memorial Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Rural - Spring Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. "Newtown"
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rosa Wilda Martin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Raphael H. Martin
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): August 9, 1879

8. AGE: Years	Months	Days	If less than one day
68 79	9	28	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: with home

FATHER
12. Name: John J. McGee
13. Birthplace: Wash, D.C.

MOTHER
14. Maiden name: Annie Reagan
15. Birthplace: Wash, D.C.

16. Informant: Raphael H. Martin
Address: Spring Hill, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-9-48 (month) (day) (year)
Cemetery or crematory: St Johns
Location: Hughesville Md
18. Funeral director: Hugh H. Ryon
Address: Waldorf Md

19. 6-8 19 48 (Date rec'd by registrar) M. L. Mouser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6, 1948 at 9:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29, 1948, to June 6, 1948
and that I last saw h-- alive on June 6, 1948

	DURATION
Immediate cause of death: Cerebral hemorrhage	8 days
Due to: Chronic glomerulonephritis with hypertension	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James L. MacKaye, M.D. M. D. or other
Address: La Plata, Md. Date signed 6-6-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The font age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

6132

CERTIFICATE OF DEATH

Reg. Dist. No. 106

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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1. PLACE OF DEATH:

County: Charles

City or town: Pomonkey

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Pomonkey

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Scotia Earnestine Middleton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband ~~or wife~~: Morris Clifton Middleton

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): Feb. 5th 1905

8. AGE: Years	Months	Days	If less than one day
43	4	4	..... hrs. ..... min.

9. Birthplace: Clarksburg, Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Vincent Skipisick

13. Birthplace: Clarksburg, Virginia

MOTHER

14. Maiden name: Nora Newton

15. Birthplace: Clarksville, Va.

16. Informant: Morris Clifton Middleton (husband)

Address: Pomonkey, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13 1948 (month) (day) (year)

Cemetery or crematory: Metro Memorial

Location: Pomonkey, Md.

18. Funeral director: Burnett & Matthews

Address: Wash. D.C.

19. June 9 1948 (Date rec'd by registrar) Odey Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9th 1948, at 7 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9th 1948, to June 9th 1948

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Percival C. Smith, M.D. M. D. or other

Address: Indian Head, Md. Date signed 6-9-48

6133

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

950

CERTIFICATE OF DEATH

Reg. Dist. No. 108

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Waldorf

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Carroll Reeves Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 13, 1931

8. AGE: Years: 17 | Months: 2 | Days: 13 | If less than one day: ..... hrs. ..... min.

9. Birthplace: ~~School~~ Brynton, Md. (Town, county, and state)

10. Usual occupation: School

11. Industry or business

FATHER — 12. Name: John Carroll Reeves

FATHER — 13. Birthplace: Chas. Co. Md.

MOTHER — 14. Maiden name: Irene Thompson

MOTHER — 15. Birthplace: Chas. Co. Md.

16. Informant: John Carroll Reeves

Address: Waldorf, Md. R.F.D.

17. Burial, cremation, or removal (Which?) Burial Date thereof 6/28/48 (month) (day) (year)

Cemetery or crematory: St. Mary's

Location: Myrtle Grove Md.

18. Funeral director: Hunter & Mason

Address: Waldorf Md.

19. 6-30 19 48 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 19 48 at 9:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 48 to June 26 19 48 and that I last saw h alive on June 26 19 48

Immediate cause of death	DURATION
RHEUMATIC HEART DISEASE	11 YRS.
Due to ACUTE LEFT VENTRICULAR FAILURE	6 Days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: John H. Griffing M.D. M. D. or other

Address: Hughesville, Md. Date signed 6/26/48

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1579 6134 105

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Charles
City or town: Hughesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1½ mo.
Hospital, institution, or street address where death occurred:
Home
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Hughesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME: William Francis Sewell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	Single

6.(b) Name of husband or wife: / /
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 23, 1948

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
0	1	13,	—	

9. Birthplace: Hughesville (Town, county, and state)
10. Usual occupation: Infant
11. Industry or business: X

FATHER
12. Name: Joseph Ambrose Sewell
13. Birthplace: Hughesville

MOTHER
14. Maiden name: Betty Douglas
15. Birthplace: Aquasco, Md.

16. Informant: Betty Douglas Sewell
Address: Hughesville, Md —

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 10 1948 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Bryantown

18. Funeral director: Joseph Ambrose Sewell Father
Address: Hughesville

19. 6-10 1948 J. McElmurry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 1948, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1948, to June 10 1948
and that I last saw him alive on June 7, 1948 1948

Immediate cause of death	DURATION
Cardiovascular Failure	
Due to: Maldevelopment of Gastrointestinal	
Due to: Post Pyloric Stenosis	
Other conditions: Marasmus	

(Include pregnancy within 3 months of death)

Major findings of operation: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Alfred R. Lapus M.D.
M. D. or other
Address: Aquasco, Md. Date signed: June 10, 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6135

CERTIFICATE OF DEATH 167

Reg. Dist. No. 106

1. PLACE OF DEATH:
County: Charles.
City or town: Indian Head, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 minutes
Hospital, institution, or street address where death occurred:
U.S. Naval Dispensary
How long in hospital or institution? 15 minutes.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Marbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Adrian Simms

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/6/05

8. AGE:

Years	Months	Days	If less than one day
43	4	17	hrs. min.

9. Birthplace Hill Top, Md. (Town, County, and state)
10. Usual occupation Laborer
11. Industry or business Construction work

FATHER
12. Name Jesse B. Simms
13. Birthplace Hill Top, Md.

MOTHER
14. Maiden name Annie E. Jacobs
15. Birthplace Hill Top Md

16. Informant Francis M. Simms
Address Marbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-27-48 (month) (day) (year)
Cemetery or crematory Woodlawn
Location ~~Hillcrest~~ Rd Washington D.C.

18. Funeral director Perry & Cole
Address Post Office, Md.

19. 6/24 1948 Okey Price Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 19 48 at 7-15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemorrhage	1/2 hr.
Due to Multiple stab wounds left thigh (specifically incised	
Due to wound left femoral artery (pocket knife)	
Other conditions Acute alcoholism	3 days

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Homicide Date of 6/23/48
Where did injury occur? Marbury (City or town) Charles (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Pocket knife Injured at work? No.

23. SIGNATURE Frederick Swann M.D.
M. D. or other
Address Indian Head Md Date signed 6-23-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M